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ABSTRACT

Based on the trend toward greater reliance on new health practitioners, this book focuses on the nurse practitioner and the physician's assistant. The first of four sections describes the nurse practitioner and the physician's assistant and what their functions are in the delivery of health care services. Discussing why new health practitioners are needed, section 2 expounds on how they will affect the supply of primary care services and how they can influence the rising cost of health care. The third section addresses the acceptance and effectiveness of new health practitioners by professional personnel and consumers. The final section discusses impediments to the full potential and utilization of new health practitioners such as licensure and the question of reimbursement for services. An annotated bibliography of suggested readings is included. (LRA)

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NEW HEALTH PRACTITIONERS: THE NURSE PRACTITIONER AND THE PHYSICIAN'S ASSISTANT

by

Barbara H. Woolley

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INTRODUCTION

Up to the end of World War II, the major limit to the provision of health services had been the lack of knowledge about health and disease. However, the rapid accumulation of biomedical knowledge in the past century and its conversion into applied technology, especially during the last two decades, has reduced the significance of this limitation. Today, we face new limitations. While we know much about the prevention and treatment of disease, we find that applying that knowledge is difficult.[1-4]

In recent years, there has been considerable concern as to whether or not certain patient care activities need to be the sole domain of the physician.[5] This concern has led to the development of a number of different types of "new health practitioners." This generic term includes the nurse practitioner (NP), physician's assistant (PA), MEDEX, physician associate, child health associate, PRIMEX, nurse clinician, nurse specialist, clinical associate, community health medic, nurse associate, and medical services assistant.

Much confusion surrounds this trend toward greater reliance on new health practitioners. The purpose of this paper is to clear up much of this confusion, with particular attention given to NPs and PAs. These two specific types of new health practitioners are probably the most numerous, and the issues surrounding their use typify most of the concerns associated with other types of new health practitioners.

This report is organized into four sections. The first describes the new health practitioners, followed by a section on why they are needed. The third section addresses the acceptance and effectiveness of new health

practitioners. The final section discusses impediments to the full potential and utilization of new health practitioners. In addition to the references used in this study (indicated by superscripts in the text), an annotated bibliography of suggested further readings has also been included.

WHO ARE THE NEW HEALTH PRACTITIONERS?

Two methods have developed to prepare new health practitioners. The first has been to create entirely new roles, such as the physician's assistant (PA), and the second has been to create expanded roles for existing health professionals, such as the nurse practitioner (NP).

The PA and NP perform certain duties that traditionally have been performed almost exclusively by the physician. Most commonly these health practitioners work in a primary care setting, that is, the point of first contact for the patient within the health care system.[6] In this setting the majority of simple illnesses and injuries can be effectively cared for by the new health practitioner and/or the physician.[7] The new health practitioners work in one of two ways--either under close supervision by a physician, as is common with the PA, or without this immediate supervision, as is common with the NP. In all instances close ties to physician back-up and referral are necessary.

The Physician's Assistant

In December 1970, the American Medical Association suggested and had approved by the House of Delegates the following working definition for the PA: "The PA is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."[8]

The concept of a PA and the delegation of physician tasks is not new; physicians have delegated tasks to a variety of personnel for years. What is new is the desire to formalize training to enable these new personnel to

perform services which extend the physician's capacities in the diagnostic and therapeutic management of patients.[9]

The development of the PA was inspired partly by the desire to use the skills of discharged medical corpsmen. These individuals were often already trained in some primary care skills and usually had extensive experience, but there was no mechanism available at that time to incorporate them into the health care delivery system. In order to formalize their role, educational programs were developed which prepared the PA by a short period of classroom preparation and clinical training for a role in primary care.* The educational programs vary in length and may culminate in either a certificate or a college degree.

The PA training program initiated at Duke University in the mid-1960s is generally acknowledged as the pioneer PA program; other programs tend to be patterned after it. Although there is no uniform standard, programs typically offer two-year curricula with the following structure:

1. First Year: training emphasizes a working knowledge of anatomy, physiology, pharmacology, and microbiology; it also provides some experience with trauma, wound healing, suturing, and handling of living tissue.

2. Second Year: training emphasizes how to take a comprehensive medical history and give a good physical exam; it also requires work in the recovery room, emergency clinic, coronary care unit, renal dialysis unit, and respiratory care unit. In addition, the PA gets experience in a private clinic, MD's office, or in the admitting service of a hospital.[10]

Generally, PAs perform an evaluative function; a PA is capable of taking a complete history and performing routine physical examinations for all patients.

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*There are other programs which prepare the PA for such specialty areas as general surgery, urology, etc.

They can order common and simple diagnostic and test procedures and can interpret the results. Often the PA performs minor surgical services, such as minor suturing and removal of foreign material from the eye.[11]

The Nurse Practitioner

Nursing represents the largest single body of health professionals in the country. The NP is licensed as a registered nurse and has academic preparation to deal with problem solving and evaluation of total patient needs. Although the development of the PA did not actually pre-date the development of the NP, the PA movement was an important factor in the development of the expanded role of the NP.[12]

Today, the traditional role of the registered nurse is expanding markedly as the nurse takes on more responsibility for diagnosing and treating patients. These capabilities allow the nurse to function in an interdependent relationship with the physician. In this relationship nursing maintains its unique role.

Like the PA, the NP functions primarily in the delivery of primary care. This includes assessing and evaluating the health status of an individual or family; screening for problems and identifying referrals; managing acute or episodic illness as well as stable chronic illnesses; providing health maintenance support to patients; counseling, coordinating all phases of patient care, and utilizing community resources to meet patient needs. Often, there is much more emphasis on the psycho-social dimensions of illness and health. Specific responsibilities may include taking histories, performing physical examinations, ordering and interpreting laboratory tests, and regulating medication and diet. Because of the

nursing profession's long history of patient care, the NP offers an excellent comprehensive addition to the primary care team.[13]

WHY NEW HEALTH PRACTITIONERS ARE NEEDED

Over the past decade, there have been significant changes occurring in the delivery of health care. Today, more than ever before, there is growing public sentiment for modifying the health care system. Part of this concern stems from the philosophy which now believes that high quality health care should be a right, not just a privilege available for only part of the population.[14] As a result, consumer demand and need for health services has become more apparent. Also evident today is a trend toward more emphasis on preventive medicine, which is partly responsible for the growing interest in primary care.

The accelerated demand for health services has confronted American medicine with three problems: (1) how to increase the supply of services; (2) how to contain the rising costs of care; and (3) how to maintain the quality of patient care. It has been suggested that the new health practitioners will help to solve the imbalance of supply and demand by (1) increasing the number of health personnel and improving the geographical distribution of providers of care, and (2) expanding the efficiency of existing health manpower. Others argue that quality may actually improve because the new health practitioners address aspects of health other than just medical care (such as identifying community resources to meet patient needs, assisting in the removal of barriers to using these needed resources, and performing counseling services).[15]

The Supply or Availability of Services

One of the key arguments in support of the new health practitioners is that they can increase the availability of primary care to underserved areas.

> There exists today a critical need for health manpower--the right numbers and kinds of people in the right places. Our needs for all kinds of health workers--professional and nonprofessional--exceed supply and present educational capacity.[3]

The issue of shortage of health manpower, typically physician shortage, is complex.[16-18] One perspective suggests there is no shortage in the total number of trained physicians but because of specialization and the geographical distribution of physicians areas of shortage exist.[4] These underserved areas tend to be the nation's rural areas and the inner core of the cities.

Recent statistics seem to support the fact that the new health practitioners are having an impact in these previously underserved areas. A 1975 survey of PAs indicates that nearly 80 percent settled in counties with less than 50,000 population. Likewise, survey data show that NPs are gravitating to such underserved places as the inner city and small rural communities.[19] Recent legislation allows for Medicare and Medicaid payment for services by NPs and PAs in rural areas, and this should reinforce the tendency of these practitioners to locate in these areas.

Influence on the Rising Costs of Health Care

One of the major advantages of using new health practitioners is their potential to increase productivity in terms of the number of patients seen.[20] This increase in patient volume may subsequently result in: (1) reduced fees or a slowing of the rate of increase in fees,[21] and (2) increased quality of health services as physicians are free to spend more time treating difficult health problems.[22] Of course, if more patients are seen, even at reduced fees, it is possible that total health care cost figures

for the nation would increase.

A number of studies have examined the potential productivity gains resulting from the hiring of new health practitioners.[23] The Reinhardt study, using a nationwide cross section of physicians, indicated that the average U.S. physician could increase hourly output by 25 percent above current average output levels with the employment of new health practitioners.[24]

Other studies suggested even greater gains in productivity as a result of using new health practitioners.[25-28] One of these studies developed a model which projected a 74 percent increase in physician productivity when it was assumed that the PA referred only the more difficult cases to the physician--from 147 patient visits per week using conventional medical workers to 265 patient visits using PAs. However, when it was assumed that both the physician and PA see each patient, the potential gain in physician productivity declined to 49 percent.

The types of tasks delegated by the physician to the new health practitioner will affect the extent of productivity gains. However, even delegation of relatively simple repetitive activities (such as physicial examinations) offers the promise of substantial increases in the productivity of the physician.

Another consideration in the use of new health practitioners in controlling rising cost of medical care is that such practitioners typically provide primary care. Offering good primary care provides preventive care and has the potential for reducing the more costly care needed by institutionalization.

ACCEPTANCE AND EFFECTIVENESS OF THE PA AND NP

Many of the issues concerning the acceptance and use of new health practitioners stem from the problems of introducing a new role or expanding an existing role into the health care system. Research findings have shown that when a new role is created (as with the PA) and is filled, that individual is given tasks for which the established work group no longer wants responsibility. Further, the established work group often finds it difficult, at first, to clearly delineate their expectations for the newcomer. Often this results in restriction of the activities the PA may perform. After an initial period of uncertainty, however, the newcomer begins to expand the scope of activities and is trusted to do so until a new equilibrium is reached. Once the new worker becomes accepted, there is less stereotyping and more acceptance; role boundaries adjust with group members recognizing each other's capabilities. The incentive to expand responsibilities for the new role generally is derived from the capabilities of the individual filling the role. Later, as roles become more established the PA may be given increased responsibilities.

The situation where a role is expanded (as in the case of the NP) means that there is an initial standard of professional skills to which additional knowledge and skills are added. Often acceptance of these expanded roles becomes more of a problem for other nurses and results in the same problems that the newcomer faces.[29]

Because existing health care professionals have had less than ten years experience with the new health practitioners, the proper roles for the new practitioners have not yet been resolved and continue to generate

controversy.[30] The following section discusses both the professional and consumer acceptance of new health practitioners.

Professional Acceptance

The successful development and inclusion of new health practitioners in the delivery of primary care depends upon a convincing demonstration that they can assume responsibility for patient care without compromising the quality of patient services.[31] The new health practitioners are being called on to play a greatly expanded and increasingly complex service role in the delivery of health care. To create their successful inclusion into the health care team there must be understanding and communication between existing health professionals and new practitioners as to the responsibilities, needs, and contributions of each.

For the physician this is especially essential. The legal liability as well as moral responsibility for patient management still remains with the physician. While the change in delivery patterns may be beneficial, the physician assumes legal responsibility and makes the primary decisions for the delegation of tasks. While acknowledging that most primary care is relatively simple and straightforward, many physicians are concerned about the risks of rare but serious illness being missed by the PA or NP. Consequently, they feel more comfortable delegating responsibility after diagnosis rather than delegating diagnosis.

The health care team approach, with each member contributing to the activities of total patient care is a new approach, not familiar to many physicians. As more physicians and nurses become prepared for roles in primary care the team relationship should become more clearly defined. These

delineations are only now beginning to be addressed. Research shows that characteristics and relationships between physicians and health practitioners are potentially complementary. In practice, however, this potential is not fully exploited, particularly by the physician.[32-33]

The nursing profession also has some difficulty accepting the expanded role and responsibilities represented by the NP. This was reflected in the slow development of the expanded role of the nurse and the fact that the nurses had psychological barriers about themselves. Traditionally, the nursing profession developed its role as supplementary to the physician, who was seen as the legitimate decisionmaker. Roles were defined by a care/cure dichotomy in which cure was the realm of the physician and care the realm of the nurse.[13, 34] As a result, it became difficult for nurses to think in terms of making diagnostic decisions. This is changing as society is beginning to give more autonomy to women and as more males enter the nursing profession. It is now becoming more acceptable for nurses to take more responsibility in decisionmaking patient care.

There has been a number of studies which have compared the performance of new health practitioners to that of physicians.[35-37] Those studies have reported that the performance of new health practitioners is comparable to physicians in: obtaining a health history, performing a medical examination, conducting well-child visits, screening, handling health problems received by telephone, and providing comprehensive health care to entire families.

The Burlington Randomized Trail study, for example, demonstrated convincingly that a NP can provide primary clinical care as safely and effectively, and with as much satisfaction to the patient, as can the physician.[38]

Another study noted that nurses moved into assuming decision-making responsibilities, formerly delegated to the physician, with minimum difficulty.[39]

Consumer Acceptance

It is not enough that new health practitioners be accepted by the medical profession and particularly by other nurses. It is also necessary that they be accepted by the people they are serving--the general public. Much of the literature and research on community attitudes toward the use of health practitioners has been positive. These studies confirm that the quality of care is perceived as good-to-excellent and that referrals and follow-ups are made smoothly, thereby increasing consumers' use and satisfaction.[40]

In some cases, however, an initial period of adjustment seems necessary before acceptance occurs. In one study, when a NP joined a pediatrician's private practice, the patients at first reacted negatively; some refused to talk with the NP and some left the practice. In addition, other physicians accused the pediatrician of unfair competition and of reducing the quality of medicine. Three years later, however, when the patients' attitudes for the same practice were evaluated, the results showed: 94 percent were satisfied with the care they received, 57 percent found the joint care to be better than the care they had received from the physician alone, and more than 90 percent considered the association between the pediatrician and the NP to be desirable and an inevitable trend in the private practice of medicine.[41] Admittedly, many who were initially dissatisfied may have left the practice, but these results also suggest a period of adjustment may be all that is needed for acceptance to occur.

Much of the concern for the use and acceptance of new health practitioners

is not substantiated by the existing literature, particularly from the consumers' standpoint. Nonacceptance of these practitioners by consumers appears to be more myth than reality. Without formal training in the team approach to health delivery, it is the health professionals, rather than the consumers, who may be skeptical of the new health practitioners.[42-44]

FACTORS WHICH IMPEDE THE USE OF NEW HEALTH PRACTITIONERS

The present organization of the health care delivery system is partly determined by the demand and need for health services. In the process of meeting these needs and demands the health professionals play a large role by first, informing the consumers of the quantities and types of health services that they need and secondly by directing the organization and supply of the health services delivered.[45] In addition, third parties, governmental programs and health insurance systems influence the organization and functioning of the health care system by paying for some kinds of care but not for others. In this process two major factors which impede the use of new health practitioners are problems associated with licensure and reimbursement for care.

Licensure

Physicians were the first group of health professionals to seek and secure protection by means of state licensure. For the most part, the licensure laws were originally enacted during the late nineteenth and early twentieth centuries as a matter of necessity to protect the public against quackery, deception, and professional incompetence. The laws are based upon the assumption that the consumer is not in a good position to evaluate the quality of professional practice and that it is the obligation of the profession to maintain the standards of care. The license laws impose ethical, educational, and licensing requirements on all those who would practice medicine and other healing arts.

Medical license laws are universally restrictive. Almost all definitions of medical practice include: diagnosis, treatment, correction, or the prevention of human disease, injuries, ailments or infirmities, be they physical or mental by any means, methods, devices, or instrumentalities.[46]

Other health professions, for example dentistry and nursing, have had to define limited areas of the health field for themselves. Physicians also set precedence by establishing state regulatory boards, composed of members of the profession, to advise state officials in matters dealing with the profession.

The procedures set by physicians were also followed by the nursing profession. Licensure of nurses followed three general phases. The first was simply registration acts. The second required mandatory licensing for all nurses and delineated two types of nurses, the registered nurse and the practical nurse, while making it illegal for any others to practice nursing. The movement for mandatory licensure spread from state to state. These two phases of licensure denied nurses the right to diagnose and treat patients; this was the exclusive realm of the physician. The most recent phase in the licensure of nurses begins to include amendments to permit the diagnosis and treatment of patients. This change is allowing growing numbers of nurses to expand their roles in primary care.[47] The restriction of activities imposed by licensure, however, is not fully resolved. Although many states have revised their laws, thus providing a model for other states, the process is not complete. The licensure practice acts for each state define the restrictions which exist for that state and outline in the practice acts what tasks the nurse may perform.

The PA

The rapid expansion of educational programs and increasing numbers of PAs available for employment have caused concern that changes in state laws and regulations be made to legally recognize and accommodate these new health personnel. Unlike, the NP, who already had a well-established licensure tradition, the PA had no legal means to perform tasks which, prior to his/her introduction, were considered solely within the province of the physicians. Hindering the development of formal licensure procedures for the PA is the possible enactment of national health insurance which has caused the government to impose a moratorium on licensure for any additional health personnel. This has resulted in each state enacting and granting legislative sanction to PAs, with no provision for a single standard.

Most states have chosen two distinct statutory forms--the general delegatory statute and the regulatory authority statute to legalize the PA.[48-49] The general delegatory statute simply amends the state medical practice act and permits PAs to work under the supervision of physicians. The regulatory authority statute authorizes the state board of medical examiners or other similar agencies to establish rules and regulations with respect to the educational and employment qualification of the PA.[50]

Legally, the PA is more vulnerable than the NP.* Although PAs are formally recognized in a number of state statutes, they still risk being sued for malpractice, and attention needs to be focused on protection for these individuals. Much of the legal problem centers around the issue of

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*NPs are less likely to encounter legal difficulties because they are largely covered by the nurse practice acts.

standard of care. Is the standard of care by which the PA and NP will be judged the same standard of skill, knowledge, and care used to evaluate physician performance? This question presumes that a patient consulting with a physician would expect that if a medical procedure is delegated to another person that person would have the same degree of knowledge and skill as the physician. The current malpractice crisis in the U.S. (i.e., high costs of malpractice insurance, increasing frequency of suits, and very high awards) has made physicians far more cautious about accepting responsibility for the work of others.

Reimbursement for Services

Another impediment in the use of new health practitioners is reimbursement for services. One of the problems is determining the level of reimbursement for the new health practitioner. This can be argued from two viewpoints. On the one hand, it can be held that services of comparable quality should receive the same level of reimbursement regardless of whether they are delivered by a physician, PA, or NP. On the other hand, it can be argued that the PA and the NP represent less costly labor--having less formal education than physicians in most cases--and therefore their use should result in lower fees. This issue is further complicated if services delivered by the PA and NP are of different quality from those delivered by the physician.

The American Medical Association (AMA) has recommended that reimbursement for services be made directly to the employing physician. In instances where the PA and NP are providing services in the physician's office and in conjunction with the physician, the cost of such services would appropriately be a part of the physician's own fee-for-service, as is now the case with the other personnnel

employed. When the new health practitioner provides services in a location physically remote from the employing physician, the AMA has recommended that the physician bill for such services on the basis of the usual, customary and reasonable charges concept.

Since much of medical costs is not provided directly from individuals but from health insurance companies, (or third party payers) or from government reimbursement (Medicare or Medicaid), it is necessary that these groups be willing to reimburse for the services rendered by the PA and the NP. Until recently, reimbursement by third party payers, Medicare, and Medicaid, for services provided without the physical presence of a physician was difficult to obtain. For example, Medicare, until December 1977, only allowed reimbursement for services rendered at facilities in which the physician was present. Thus, isolated clinics where no physician was present were left without reimbursement. With the passing of the Rural Health Clinics Bill in December 1977, reimbursements by Medicare/Medicaid for services provided by PAs and NPs, even if a physician is not present, became a reality. Under this legislation, reimbursement is made directly to the agency operating the rural clinic and not to the individual provider. This single piece of legislation provides the first step to resolving some of the restrictions imposed by reimbursement for care.

Summary

New health professionals, like physician's assistants and nurse practitioners, can help meet the increasing demands for primary health care in the United States, particularly in such previously underserved areas as the inner cities and rural areas.

Questions remain, however, as to the effect the new health practitioners will have on costs and on maintaining quality of health care. Other stumbling blocks being met by new health practitioners are matters of consumer-professional acceptance, licensure, and the question of reimbursement for services.

Research has shown that new health practitioners have the potential to help meet today's health care demands. Time and experience in the field has also helped reduce many of the barriers affecting the full utilization of the new health practitioners.

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   This directory contains information on operating training programs and is updated periodically. Information includes (1) scope and emphasis of programs, (2) length of program, (3) education setting (i.e., medical school, college, etc.), (4) prerequisites for admission, and (5) credentials awarded

LEGAL STATUS

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   An excellent summary of the legal status and reimbursement situation for NPs and PAs in each state. For additional update contact your state licensing board.

PHYSICIAN'S ASSISTANT

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